X-Ray Release Authorization

Patient Name

Address

Date of Birth

I hereby authorize and request you to release a copy of any x-rays taken within the last 3 years to Shoreline Dental Care, LLC. (Dr. Joseph D. Tartagni, D.M.D & Dr. Jason Tartagni, D.M.D & Associates)

Please indicate location to send x-rays:

369 Main Street
West Haven, CT 06516
Tel: (203) 931-3050
Fax: (203) 931-3055

255 Cherry Street, Suite C
Milford, CT 06460
Tel: (203) 874-3050
Fax: (203) 874-3990

Dental Office in which x-rays are being sent from:

Notes:

X-rays can be emailed to: **smiles@shorelinedentalcare.com**
Please email the x-rays in JPEG format and indicate the date(s) taken.
If you do not use digital radiography, please duplicate the x-rays to the highest quality possible and mail them to our office.